**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at ***www.auxiant.com*** or by calling **1-800-279-6772**.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | For Network:<br>**$500** person/**$1,000** family per calendar year<br><br>For Non-Network:<br>**$1,000** person/**$2,000** family per calendar year<br><br>***Deductible*** does not apply to network routine care. | You must pay all the costs up to the ***deductible*** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the ***deductible*** starts over (on January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the ***deductible***.<br><br>Network/Non-Network ***deductibles*** and any other benefit maximums cross-satisfy one another. |
| **Are there other deductibles for specific services?** | There are no other specific medical ***deductibles***. | Because you don't have to meet ***deductibles*** for specific services, this plan starts to cover costs sooner. |
| **Is there an out–of–pocket limit on my expenses?** | For Network:<br>**$1,300** person/**$2,600** family per calendar year<br><br>For Non-Network:<br>**$2,600** person/**$5,200** family per calendar year | The ***out-of-pocket limit*** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. Network/Non-Network ***out-of-pocket limits*** cross-satisfy one another. Any other benefit maximums do cross-satisfy one another.<br>The deductible is included in the ***out-of-pocket limit***. The ***out-of-pocket limit*** and Prescription costs combined shall not exceed the federal maximum of $6,850 per person and $13,700 per family. |
| **What is not included in the out–of–pocket limit?** | Cost containment penalties, ineligible charges, amounts over the usual & customary, premiums, balanced-billed charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the ***out-of-pocket limit***. |
| **Is there an overall annual limit on what the plan pays?** | No. This policy has no overall annual limit on the amount it will pay each year. | This plan will pay for covered services only up to this limit during each policy period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 3 describes any limits on what the insurer will pay for specific covered services, such as office visits. |

| | | |
|---|---|---|
| **Does this plan use a network of providers?** | Yes. Please contact your Employer for a list of these providers. | If you use an in-network doctor or other health care ***provider***, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network ***provider*** for some services. Plans use the term in-network, ***preferred***, or participating for ***providers*** in their ***network***. See the chart starting on page 3 for how this plan pays different kinds of ***providers***. |
| **Do I need a referral to see a specialist?** | No, you do not need a referral to see a specialist. | You can see the specialist you choose without permission from this plan. If the specialist is not in your network, the coverage is at an out of network cost. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 9. See your plan document for additional information about excluded services under ***General Limitations***. |

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

| Common Medical Event | Services You May Need | Your cost if you use an In-network Provider | Your cost if you use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | Deductible then 10% coinsurance | Deductible then 40% coinsurance | none |
| | Specialist visit | Deductible then 10% coinsurance | Deductible then 40% coinsurance | none |
| | Other practitioner office visit | Deductible then 10% coinsurance | Deductible then 40% coinsurance | Applies to Chiropractic care, Chemo/Radiation therapy, Cardiac Rehab therapy, Hemodialysis, Occupational therapy, Physical therapy, and Speech therapy.<br>Chiropractic care, Occupational therapy, Physical therapy, and Speech therapy are subject to medical necessity after the first 25 visits.<br>Pre-authorization is required for Chemo/Radiation. |
| | Preventive care – Routine Well Care | 0% coinsurance and no deductible | Deductible then 40% coinsurance | Includes: Mammograms, Pap Smear, Prostate Screening, Routine Surgeries (colonoscopy, sigmoidoscopy, proctoscopy, etc.), Immunizations, and Routine Exams, Well Child Care, Routine Vision exams (to age 5), X-rays, All other lab tests, and Tobacco Cessation office visits/counseling.<br><br>Mammograms, PSA, Pap smear, and prostate exam are each limited to one per calendar year. |

| Common Medical Event | Services You May Need | Your cost if you use an In-network Provider | Your cost if you use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have a test** | Diagnostic test (x-ray, blood work) | Deductible then 10% coinsurance | Deductible then 40% coinsurance | none |
| | Imaging (CT/PET scans, MRIs) | Deductible then 10% coinsurance | Deductible then 40% coinsurance | none |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.optumrx.com | Generic drugs | $5 Copay per prescription (retail); $10 Copay per prescription (mail order) | N/A | Out-of-pocket limit applies. $5,300 single / $10,600 family<br><br>Covers up to a 34-day supply (retail & specialty); 35-90 day supply (mail order)<br><br>No co-pay for generic women's contraceptives. |
| | Preferred Brand Name drugs | $25 Copay per prescription (retail); $50 Copay per prescription (mail order) | N/A | |
| | Non-Preferred Brand Name drugs | $50 Copay per prescription (retail); $100 Copay per prescription (mail order) | N/A | |
| | Specialty Drugs | $25 copay | | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Deductible then 10% coinsurance | Deductible then 40% coinsurance | none |
| | Physician/surgeon fees | Deductible then 10% coinsurance | Deductible then 40% coinsurance | none |

| Common Medical Event | Services You May Need | Your cost if you use an In-network Provider | Your cost if you use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need immediate medical attention** | Emergency room services | $100 copay then Deductible then 10% coinsurance | Paid at Network Level | Copay waived if admitted. Copay does not apply to physician services. |
| | Emergency medical transportation | Deductible then 10% coinsurance | Paid at Network Level | none |
| | Urgent Care Room | Deductible then 10% coinsurance | Deductible then 40% coinsurance | none |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Deductible then 10% coinsurance | Deductible then 40% coinsurance | none |
| | Physician/surgeon fee | Deductible then 10% coinsurance | Deductible then 40% coinsurance | none |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | Deductible then 10% coinsurance | Deductible then 40% coinsurance | Emergency Room, Urgent Care, Office evaluation & management, Office counseling, and Lab/X-ray charges are paid same as any other illness. |
| | Mental/Behavioral health inpatient services | Deductible then 10% coinsurance | Deductible then 40% coinsurance | none |
| | Substance use disorder outpatient services | Deductible then 10% coinsurance | Deductible then 40% coinsurance | Emergency Room, Urgent Care, Office evaluation & management, Office counseling, and Lab/X-ray charges are paid same as any other illness. |
| | Substance use disorder inpatient services | Deductible then 10% coinsurance | Deductible then 40% coinsurance | none |
| **If you are pregnant** | Prenatal and postnatal care | Paid same as any other illness | Paid same as any other illness | Home births are not covered. |
| | Delivery and all inpatient services | Paid same as any other illness | Paid same as any other illness | Home births are not covered. |

| Common Medical Event | Services You May Need | Your cost if you use an In-network Provider | Your cost if you use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | Deductible then 10% coinsurance | Deductible then 40% coinsurance | Limited to 40 visits per calendar year. |
| | Rehabilitation services | Deductible then 10% coinsurance | Deductible then 40% coinsurance | ——none—— |
| | Habilitation services | Not Covered | Not Covered | ——none—— |
| | Skilled nursing care | Deductible then 10% coinsurance | Deductible then 40% coinsurance | Limited to 30 days per confinement. |
| | Durable medical equipment | Deductible then 10% coinsurance | Deductible then 40% coinsurance | ——none—— |
| | Hospice service | Deductible then 10% coinsurance | Deductible then 40% coinsurance | ——none—— |
| **If your child needs dental or eye care** | Eye exam | See Preventive Care Benefits | See Preventive Care Benefits | Routine vision exams are covered under the Preventive Care benefit. |
| | Glasses | Not Covered | Not Covered | Only charges for initial contact lenses or eyeglasses following cataract surgery or aphakia surgery are covered. |
| | Dental check-up | Not Covered | Not Covered | ——none—— |

## Excluded Services & Other Covered Services:

| **Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other *excluded services*.)** | | |
|---|---|---|
| • Acupuncture<br>• Cosmetic surgery<br>• Dental care (Adult) | • Infertility treatment<br>• Long-term care<br>• Non-emergency care when traveling outside the U.S. | • Routine eye care (Adult)<br>• Routine foot care<br>• Weight loss programs |
| **Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)** | | |
| • Bariatric surgery<br>• Chiropractic care | • Hearing aids | • Private-duty nursing |

### Your Rights to Continue Coverage:
You can keep this coverage as long as you pay your premium, unless one of the following things happen:
- You commit fraud or misrepresentations of a material fact
- The plan sponsor terminates this plan
- Your employment terminates and you are not eligible to continue coverage under COBRA or state law.

### Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You can also contact Auxiant at 2450 Rimrock Road, Ste 301, Madison, WI 53713.

### Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

### Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

## Having a baby
(normal delivery)

- **Amount owed to providers:** $7,444
- **Plan pays** $6,243
- **Patient pays** $1,201

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,672 |
| Routine obstetric care | $2,084 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $527 |
| Prescriptions | $150 |
| Radiology | $176 |
| Vaccines, other preventive | $35 |
| **Total** | **$7,444** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $500 |
| Co-pays | $25 |
| Co-insurance | $676 |
| Limits or exclusions | $0 |
| **Total** | **$1,201** |

## Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,418
- **Plan pays** $4,170
- **Patient pays** $1,248

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,849 |
| Medical Equipment and Supplies | $1,279 |
| Office Visits and Procedures | $852 |
| Education | $161 |
| Laboratory tests | $137 |
| Vaccines, other preventive | $140 |
| **Total** | **$5,418** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $500 |
| Co-pays | $200 |
| Co-insurance | $153 |
| Limits or exclusions | $394 |
| **Total** | **$1,248** |

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include ***premiums***.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network ***providers***. If the patient had received care from out-of-network ***providers***, costs would have been higher.

**2016 Police Local and Sups Health Plan Monthly Deductions**

W/ BIOMETRIC: SINGLE $43.60; FAMILY $113.30
WITH HRA: SINGLE $54.50; FAMILY $141.60
NO HRA: SINGLE $65.40; FAMILY $169.90

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how ***deductibles***, ***co-payments***, and ***co-insurance*** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your ***providers*** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the ***premium*** you pay. Generally, the lower your ***premium***, the more you'll pay in out-of-pocket costs, such as ***co-payments***, ***deductibles***, and ***co-insurance***. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.